



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

***7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645***

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### ***GENERAL INFORMATION***

**Requestor Name and Address:**

HORIZON EVALUATORS, INC.  
11058 REGENCY GREEN DRIVE  
CYPRESS, TX 77429

DWC Claim #: 10364857  
Injured Employee: ADRIAN VALENCIA  
Date of Injury: 05/19/10  
Employer Name: SAFELITE GROUP INC  
Insurance Carrier #: YYT07749 C

**Respondent Name:**

AMERICAN ZURICH INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Tracking Number:**

M4-12-0363-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "The EOR states the reason for denial is 'Based on the findings of a review organization, Unnecessary medical treatment based on peer review.' On 5/11/11 I receive a call from Cheryl T with approval notice for Chronic Pain Management, Ms. Cheryl also state there was a dispute on file regarding compensability of injury and the only acceptable Injury is Right Shoulder Sprain/Strain. We only bill for the Right Shoulder Sprain & Strain ICD-9 Code 840.9."

**Amount in Dispute:** \$7,200.00

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "The carrier has accepted only a right should strain as the full extent of the compensable injury. A copy of carrier's PLN-11 is attached. The treatment dates are June 13, 2011 to June 17, 2011, over a year after the date of injury."

**Response Submitted by:** Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

## ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2011 June 14, 2011 June 15, 2011 June 16, 2011 June 17, 2011	CPT Code 97799-CP 8 Units per day	\$7,200.00	\$4,000.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization of certain services/treatments.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 15, 2011 and September 27, 2011:

- 214 – Workers Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
- 216 – Based on the findings of a review organization.
- W9 – Unnecessary medical treatment based on peer review.
- 18 – Duplicate claim/service.

### **Issues**

1. Did the Requestor bill the insurance carrier using the accepted diagnosis code for the compensable injury?
2. Did the Respondent incorrectly deny the service/treatment in accordance with 28 Texas Administrative Code §134.600(c)(1)(B)?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. According to the PLN-11 submitted by the insurance carrier's agent, the compensable injury is limited to a strain/sprain of the right shoulder. Review of the CMS-1500's shows the requestor billed diagnosis code 840.9, which is defined as "Sprain and strain of unspecified site of shoulder and upper arm." Therefore, the denial of "214 - Workers Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment" is not supported.
2. The insurance carrier denied disputed services with reason codes "216 – Based on the findings of a review organization" and "W9 – Unnecessary medical treatment based on peer review." 28 Texas Administrative Code §133.240(b), effective May 2, 2006, 31 TexReg 3544, states that "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments)" Review of the submitted information finds documentation to support that the health care provider obtained preauthorization for the disputed services. The Division finds that the insurance carrier denied reimbursement based on medical necessity for health care for which the provider had obtained preauthorization. The insurance carrier has therefore failed to meet the requirements of §133.240(b). This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. In accordance with 28 Texas Administrative Code §134.204(h)(5)(b) reimbursement shall be \$125 per hour.

Per §134.204(h)(1)(B) "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR." The requestor did not indicate CARF accreditation; therefore, the hourly reimbursement shall be 80 percent of the MAR, or \$100 per hour. The requestor billed code 97799-CP for 8 hours per visit for 5 visits for a total of 40 hours x \$100 = \$4,000.00. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4,000.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$4,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	_____
Signature	Medical Fee Dispute Resolution Officer	Date

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**